MetLife

METROPOLITAN LIFE INSURANCE COMPANY
NEW JERSEY EMPLOYEE
STATEMENT OF CLAIM
FOR
ACCIDENT AND SICKNESS WEEKLY BENEFITS

P.O. Box 14590
Lexington, KY 40512
Fax: 1-866-690-1264

Metropolitan Life Insurance Company

(Please answer all questions)

TO BE COMPLETED BY THE EMPLOYEE

1. Your name *(Print)* _____ Phone _____ (Include area code)

2. Present address: No. ____ Street _____ City _____ State _____ Zip Code _____

☐ Male ☐ Female Date of birth mm/dd/yy ☐ Single ☐ Married Social Security No. ☐☐☐☐☐☐☐☐☐

3. Date you were first disabled by this sickness or injury mm/dd/yy

4. If you were hospitalized *as a bed patient,* please answer the following.

(a) Name and address of hospital _____

(b) Date admitted mm/dd/yy at ____ (Hour) {am. p.m. *(c)* Date discharged mm/dd/yy at ____ (Hour) {am. p.m.

5. Was an accident involved? ☐ Yes ☐ No If yes, please answer the following:

(a) When did the accident happen? Date mm/dd/yy at ____ (Hour) {am. p.m.

(b) Where did the accident happen? City _____ State _____

(c) Were you at work when the accident happened? ☐ Yes ☐ No

(d) Give a brief description of the accident _____

I authorize the Physician to release any information requested with respect to this Claim.
I certify that the information I furnished to support this claim is true and correct. ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

Date mm/dd/yy Signed *(Insured Employee)* _____

(Please answer all questions)

TO BE COMPLETED BY THE EMPLOYER

1. Employee's name _____ Social Security No. ☐☐☐☐☐☐☐☐☐

Date of Hire mm/dd/yy Current Occupation _____ Job Title _____

Premium Contributions:

Employer _____% Employee _____% ☐ Pre-Tax ☐ Post-Tax

2. Furnish the record of the employee's insurance under part *(a)* below. Part *(b)* is to be completed only if applicable:

(a) Private plan temporary disability benefits:

Amount of weekly benefit, $_____ Effective date of employee's insurance mm/dd/yy

It this coverage has been canceled, give the date and reason _____

(b) Supplernentary accident and sickness weekly benefits, if any:

Arnount of additional weekly benefit, $_____ Effective date of employee's insurance mm/dd/yy

It this coverage has been canceled, give the date and reason _____

3. *(a)* Date last worked mm/dd/yy *(b)* Date returned to work mm/dd/yy

4. If salary continued, give date salaty paid through mm/dd/yy

5. Is this employee claiming or receiving worker's cornpensation benefits? ☐ Yes ☐ No

If Yes, what is the present status of the compensation claim? _____

6. Give any information which might assist Metropolitan Life in the consideration of this claim _____

Employer Name: _____

Report Number: _____ *Subdivision* _____ *Branch:* _____

Date mm/dd/yy

Authorized Representative _____ _____
name *title*

Telephone Number (include area code): _____

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ATTENDING PHYSICIAN'S STATEMENT

_____ **Age** _____

Nautre of sickness or injury (Describe complications, if any) _____

_____

is condition due to pregency? ☐ Yes ☐ No If yes, what is the expected delivery date? mm/dd/yy

If pregency terminated please indicate date mm/dd/yy and manner (Normal deivery,

caesarean, miscarriage, etc.) _____

Did patient suffer any totally disabling complication of pregency? Yes _____ No _____

If yes, please indicate full diagnosis and/or details describing the complication _____

_____

_____

Did this sickness or injury arise out of patient's employment? ☐ **Yes** ☐ **No**

If "yes," explain _____

_____

Nature of surgical procedure, if any (Describe fully) _____

_____

_____

Date performed mm/dd/yy

Give dates of treatments:

Office _____

Home _____

Hospital _____

The patient has been continuously disabled (unable to work) from mm/dd/yy

The patient was, or will be able to return to work on mm/dd/yy

Remarks: _____

_____

Date mm/dd/yy

Name ***(please print)*** _____

(Attending Physician)

Address _____

_____

Phone Number (Include Area Code) _____

Signature _____

FOR USE BY METROPOLITIAN LIFE INSURANCE COMPANY

DIAG. CODE		THR. DATE	CALL UP WEEKS	DAYS WORKED	ACC.	LETTER NO.	DISP.	SURP.	CTL.		APPR. NO.	DATE OF REVIEW
1.					YES							
2.					NO							
3.					AUTO